Carolina Kids Pediatric Associates, PLLC

Patient Information: *Please list all children on this form to avoid having to complete a separate form for each child.*

Patient #1: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

Patient #2: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

Patient #3: Name: Last First Middle

DOB Sex: (circle) M F patients ≥ 15 yrs Cell Nickname

If more than 3 children, ask for a second form and list names here:

Children's Primary Address ☐ Mom ☐ Dad ☐ Other (Name and relationship)

First Parent Contact: Relationship to patient Name: Last First MI

DOB Cell Phone Home Phone Maiden

Address Apt/Unit #

City State Zip Email (printed clearly)

Second Parent Contact: Relationship to patient Name: Last First MI

DOB Cell Phone Home Phone Maiden

Address Apt/Unit #

City State Zip Email (printed clearly)

Alternate or Emergency Contact: Name: Last First MI

DOB Relationship Phone Authorized to oversee pt care? ☐ Yes ☐ No

Primary Insurance Info: *Our office has contractual timely filing limits with insurance providers. Therefore, you may be responsible for claim balances if valid ins info is not provided within 75 days of service.* You **must** present the patient's valid insurance policy information **before** we can file your claims. *Remaining balance or non-covered charges are the responsibility of the responsible party indicated below.* **To prevent filing errors DO NOT provide secondary insurance info unless it is Medicaid.**

Primary Insurance Co Patient policy ID# Group#

Policy Holder: Name DOB Relationship to Patient

Primary Provider: (circle one) Tanaka Willey Nechyba Emmet Helton

First Language Race Ethnicity (circle) Hispanic Non-Hispanic

How should we contact you for: **Well Check recalls** ☐ Call ☐ Text ☐ Email **Test Results**: ☐ Call ☐ Text ☐ Email

Appointment Reminders ☐ Call ☐ Text ☐ Email All emails and texts are generated by our EMR.

Responsible Party Info: ***You CANNOT delegate another person to be the responsible party.*** *Please complete this form in full today and request a blank form to take home if you plan to arrange for the responsible party to be changed.* ***Copays and balance payments are expected at time of service, regardless of custodial agreements.*** *I authorize Carolina Kids Pediatric Associates to file insurance claims for services provided and for payments of services to be made to same.*

Name: Last First Middle

DOB Relationship to patient Employer

Address Apt/Unit #

City State Zip Phone

Responsible Party Name: Print Signature Date

I have received a copy of Carolina Kids "Billing 101" ☐ YES ☐ NO, if no please request one and check yes.

I have received a copy of Carolina Kids "Privacy Practices" ☐ YES ☐ NO, if no please request one and check yes.

Person Completing Form: Print Name Signature Date